STATEMENT OF EMERGENCY

907 KAR 1:604E

(1) This emergency administrative regulation is being promulgated in conjunction with 907 KAR 1:913E, Repeal of 907 KAR 1:900, as the Department for Medicaid Services (DMS) is adopting a uniform array of services and cost sharing for Medicaid recipients and eliminating the four (4) benefit plans – Comprehensive Choices, Family Choices, Global Choices, and Optimum Choices – to which Medicaid recipients are assigned. DMS is also promulgating this emergency administrative regulation to eliminate premiums for Kentucky Children's Health Insurance Program (KCHIP) participants as the biennium budget suspended the premiums. Additionally, DMS is promulgating this emergency administrative regulation to define preventive services to comport with federal law and regulation as they are federally exempt from cost sharing and to establish that DMS's cost sharing provisions are contingent upon the receipt of federal funding and federal approval.

(2) This action must be taken on an emergency basis to comply with federal requirements and with the biennium budget as well as to prevent a potential loss of state funds.

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation is identical to this emergency administrative regulation.

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Steven L. Beshear
Governor

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Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Commissioner's Office

(Emergency Amendment)

907 KAR 1:604E. Recipient cost-sharing.

RELATES TO: KRS 205.560, 205.6312, 205.6485, 205.8451, 319A.010, 327.010, 334A.020, 42 C.F.R. 430.10, 431.51, 447.15, 447.21, 447.50, 447.52, 447.53, 447.54, 447.59, 457.224, 457.310, 457.505, 457.510, 457.515, 457.520, 457.530, 457.535, 457.570, 42 U.S.C. 1396a, 1396b, 1396c, 1396d, 1396o, 1396r-6, 1396r-8, 1396u-1, 1397aa -1397jj

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6312(5), 205.6485(1), 42 C.F.R. 431.51, 447.15, 447.50 through 447.82[~~447.51, 447.53, 447.54, 447.55, 447.57,~~] 457.535, 457.560, 42 U.S.C. 1396r-6(b)(5)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds[~~for the provision of medical assistance to Kentucky's indigent citizenry~~]. KRS 205.6312(5) requires the cabinet to promulgate administrative regulations that implement copayments [~~or other similar charges~~] for Medicaid recipients. [~~KRS 205.6485(1)(c) requires the cabinet to establish, by administrative~~

~~regulation, premiums for families with children in the Kentucky Children's Health Insurance Program. 42 U.S.C. 1396r-6(b)(5) allows for a monthly premium in the second six (6) months of transitional medical assistance.~~] This administrative regulation establishes the provisions relating to Medicaid Program[~~imposing and collecting~~] copayments[~~, coinsurance and premiums from certain recipients~~].

Section 1. Definitions. (1) [~~"Coinsurance" means a percentage of the cost of a Medicaid benefit that a recipient is required to pay.~~

~~(2) "Comprehensive choices" means a benefit plan for an individual who:~~

~~(a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;~~

~~(b) Receives services through either:~~

~~1. A nursing facility in accordance with 907 KAR 1:022;~~

~~2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;~~

~~3. The Home and Community Based Waiver Program in accordance with 907 KAR 1:160; or~~

~~4. The Model Waiver II Program in accordance with 907 KAR 1:595; and~~

~~(c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.~~

~~(3)~~] "Copayment" means a dollar amount representing the portion of the cost of a Medicaid benefit that a recipient is required to pay.

(2)[~~(4)~~] "Department" means the Department for Medicaid Services or its designee.

(3) “DMEPOS” means durable medical equipment, prosthetics, orthotics, and supplies.

(4)[~~(5)~~] "Drug" means a covered drug provided in accordance with 907 KAR 1:019 for which the Department for Medicaid Services provides reimbursement.

(5) “Enrollee” means a Medicaid recipient who is enrolled with a managed care organization.

(6) [~~"Family choices" means a benefit plan for an individual who:~~

~~(a) Is covered pursuant to~~

~~1. 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u-1;~~

~~2. 42 U.S.C. 1396a(a)(52) and 1396r-6 (excluding children eligible under Part A or E of Title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);~~

~~3. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);~~

~~4. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);~~

~~5. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or~~

~~6. 42 C.F.R. 457.310; and~~

~~(b) Has a designated package code of 2, 3, 4, or 5.~~

~~(7)~~] Federal Poverty Level" or "FPL" means guidelines that are updated annually in the Federal Register by the United States Department of Health and Human Services under authority of 42 U.S.C. 9902(2).

(7)[~~(8) Global choices" means the department's default benefit plan, consisting of individuals designated with a package code of A, B, C, D, or E and who are included in one (1) of the following populations:~~

~~(a) Caretaker relatives who:~~

~~1. Receive K-TAP benefits and are deprived due to death, incapacity, or absence;~~

~~2. Do not receive K-TAP benefits and are deprived due to death, incapacity, or absence; or~~

~~3. Do not receive K-TAP benefits and are deprived due to unemployment;~~

~~(b) Individuals aged sixty-five (65) and over who receive SSI benefits and:~~

~~1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or~~

~~2. Receive SSP benefits and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(c) Blind individuals who receive SSI benefits and:~~

~~1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or~~

~~2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(d) Disabled individuals who receive SSI benefits and:~~

~~1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, including children; or~~

~~2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;~~

~~(g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance~~

~~with 907 KAR 1:022;~~

~~(h) Pregnant women; or~~

~~(i) Medicaid works individuals.~~

~~(9)~~] "KCHIP" means the Kentucky Children's Health Insurance Program.

(8)[~~(10)~~] "KCHIP - Separate Program" means a health benefit program for individuals with eligibility determined in accordance with 907 KAR 4:030, Section 2.

(9) "Managed care organization" or "MCO" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(10)[~~(11) "K-TAP" means Kentucky's version of the federal block grant program of Temporary Assistance for Needy Families (TANF), a money payment program for children who are deprived of parental support or care due to:~~

~~(a) Death;~~

~~(b) Continued voluntary or involuntary absence;~~

~~(c) Physical or mental incapacity of one (1) parent or stepparent if two (2) parents are in the home; or~~

~~(d) Unemployment of one (1) parent if both parents are in the home.~~

~~(12)~~] "Medicaid works individual" means an individual who:

(a) But for earning in excess of the income limit established under 42 U.S.C. 1396d(q)(2)(B) would be considered to be receiving supplemental security income;

(b) Is at least sixteen (16), but less than sixty-five (65), years of age;

(c) Is engaged in active employment verifiable with:

1. Paycheck stubs;

2. Tax returns;

3. 1099 forms; or

4. Proof of quarterly estimated tax;

(d) Meets the income standards established in 907 KAR 20:020,; and

(e) Meets the resource standards established in 907 KAR 20:025.

(11)[~~(13)~~] "Nonemergency" means a condition which does not require an emergency service pursuant to 42 C.F.R. 447.53.

(12)[~~(14)~~] "Nonpreferred brand name drug" means a brand name drug that is not on the department's preferred drug list.

(13)[~~(15) "Optimum choices" means a benefit plan for an individual who:~~

~~(a) Meets the intermediate care facility for individuals with mental retardation or a developmental disability patient status criteria established in 907 KAR 1:022;~~

~~(b) Receives services through either:~~

~~1. An intermediate care facility for individuals with mental retardation or a developmental disability in accordance with 907 KAR 1:022; or~~

~~2. The Supports for Community Living Waiver Program in accordance with 907 KAR 1:145; and~~

~~(c) Has a designated package code of S, T, U, V, W, X, Z, 0, or 1.~~

~~(16)~~] "Preferred brand name[~~brand-name~~] drug" means a brand name[~~brand-name~~] drug:

(a) For which no generic equivalent exists which has a more favorable cost to the department; and

(b) Which prescribers are encouraged to prescribe, if medically appropriate.

(14) “Preventive service” means:

(a) For a child:

1. An immunization recommended by the Centers for Disease Control; or

2. A preventive service:

a. Rated grade A or B by the United States Preventive Services Task Force (USPSTF); and

b. Recommended for children and adolescents by the USPSTF; or

(b) For an adult, a preventive service:

1. Rated grade A or B by the United States Preventive Services Task Force (USPSTF); and

2. Recommended for adults by the USPSTF.

(15)[~~(17) "Premium" means an amount paid periodically to purchase health care benefits.~~

~~(18)~~] "Recipient" is defined in KRS 205.8451 and applies to an individual who has been determined eligible to receive benefits under the state’s Title XIX or Title XXI program in accordance with Title 907 of the Kentucky Administrative Regulations[~~907 KAR Chapters 1 through 4~~].

(16)[~~(19)~~] "Transitional medical assistance" or "TMA" means an extension of Medicaid benefits in accordance with 907 KAR 20:005, Section 5(5)[~~for up to twelve (12) months for families who lose Medicaid eligibility solely because of increased earnings or hours of employment of the caretaker relative or loss of earning disregards in accordance with 907 KAR 1:011, Section 5(8)(b)~~].

Section 2. [~~Comprehensive Choices~~] Copayments [~~and Coinsurance~~]. (1) The follow-

ing table establishes the:

(a) Copayment amounts that a recipient shall pay, unless the recipient is exempt from cost sharing pursuant to Section 3(1) of this administrative regulation; and

(b) [~~Except for an individual excluded pursuant to Section 6(1) of this administrative regulation, a recipient of the comprehensive choices plan shall pay the copayment or coinsurance amount established in this table, with the~~] Corresponding provider reimbursement deductions.

Benefit	Copayment [~~or Coinsurance~~] Amount	Amount of Copayment [~~or Coinsurance~~] Deducted from Provider Reimbursement
Acute inpatient hospital admission	$50[~~$10~~] copayment	Full amount of the copayment
Outpatient hospital or ambulatory surgical center visit	$4[~~$3~~] copayment	Full amount of the copayment
Generic prescription drug [~~or an atypical anti-psychotic drug if no generic equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medicare Part D drug coverage~~]	$1 copayment	Full amount of the copayment

Preferred brand name drug [~~for a recipient who does not have Medicare Part D drug coverage~~]	$4[~~$2~~] copayment	Full amount of the co-payment
Nonpreferred brand name drug [~~for a recipient who does not have Medicare Part D drug coverage~~]	$8[~~5% coinsurance, not to exceed $20 per nonpreferred brand name drug prescription~~]	Full amount of the co-payment[~~coinsurance, not to exceed $20 per nonpreferred brand name drug prescrip-tion~~]
Emergency room for a nonemergency visit	$8[~~5% coinsurance, up to a maximum of $6~~]	Full amount of the co-payment[~~No deduction~~]
DMEPOS	$4[~~3% coinsurance up to a maximum of $15 per item~~]	Full[~~The~~] amount of the copay-ment[~~coinsurance or, if applicable, $15~~]
Podiatry office visit	$3[~~$2~~] copayment	Full amount of the co-payment
Chiropractic office visit	$3	Full amount of the co-payment
Dental office visit	$3	Full amount of the co-payment

Optometry office visit	$3	Full amount of the co-payment
General ophthalmological office visit	$3	Full amount of the co-payment
Physician office visit	$3	Full amount of the co-payment
Office visit for care by a physician assistant, an advanced practice registered nurse, a certified pediatric and family nurse practitioner, or a nurse midwife	$3	Full amount of the co-payment
Office visit for care by a behavioral health professional	$3	Full amount of the co-payment
Office visit to a rural health clinic	$3	Full amount of the co-payment
Office visit to a federally qualified health center	$3	Full amount of the co-payment
Office visit to a primary care center	$3	Full amount of the co-payment
Physical therapy office visit	$3	Full amount of the co-payment
Occupational therapy office	$3	Full amount of the co-

visit		payment
Speech therapy office visit	$3	Full amount of the co-payment
Laboratory, diagnostic, or radiological service	$3	Full amount of the co-payment

(2) [~~A recipient shall not be liable for more than:~~

~~(a) $225 per calendar year for prescription drug copayments or coinsurance; or~~

~~(b) $225 per calendar year for service copayments or coinsurance.~~

~~(3)~~] The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

[~~(4) If a service or benefit is not listed in the comprehensive choices cost-sharing grid, the cost-sharing obligation shall be $0 for that service or benefit for an individual in the comprehensive choices benefit plan~~].

Section 3. [~~Family Choices Copayments and Coinsurance. (1)(a) Except for an individual excluded in accordance with Section 6(1) of this administrative regulation, only KCHIP children shall be family choices individuals subject to copayments or coinsurance.~~

~~(b) An individual referenced in paragraph (a) of this subsection shall pay the copayment or coinsurance amounts established in the following table, along with the corresponding provider reimbursement deductions.~~

~~Benefit~~	~~Copayment or Coinsur-~~	~~Amount of Copayment or Coinsur-~~

	ance Amount	ance Deducted from Provider Reimbursement
Allergy service or testing (no co-payment exists for injections)	$2 copayment	Full amount of copayment
Generic prescription drug or atypical anti-psychotic drug if no generic equivalent exists	$1 copayment	Full amount of copayment
Preferred brand name drug	$2 copayment	Full amount of copayment
Nonpreferred brand name drug	$3 copayment	Full amount of the copayment
Emergency room for a nonemergency visit	5% coinsurance, up to a maximum of $6	No deduction

(2) A recipient shall not be liable for more than:

(a) $225 per calendar year for prescription drug copayments or coinsurance; or

(b) $225 per calendar year for service copayments or coinsurance.

(3) The maximum amount of cost-sharing shall not exceed five (5) percent of a fami-

ly's income for a quarter.

(4) If a service or benefit is not listed in the family choices cost-sharing grid, the cost-sharing obligation shall be $0 for that service or benefit for an individual in the family choices benefit plan.

Section 4. Global Choices Copayments and Coinsurance. (1) Except for an individual excluded pursuant to Section 6(1) of this administrative regulation, a recipient of the global choices plan shall pay the copayment or coinsurance amount established in this table, with the corresponding provider reimbursement deductions.

Benefit	Copayment or Coinsurance	Copayment or Coinsurance Amount Deducted from Provider Reimbursement
Acute inpatient hospital admission	$50 copayment	Full amount of copayment
Outpatient hospital or ambulatory surgical center visit	$3 copayment	Full amount of copayment
Laboratory, diagnostic or radiology service	$3 copayment	Full amount of copayment
Physician services	$2 copayment	No deduction
Visit to a rural health clinic, a primary care center, or a federally qualified health	$2 copayment	Full amount of copayment

~~center~~		
~~Dental office visit~~	~~$2 copayment~~	~~No deduction~~
~~Physical therapy~~	~~$2 copayment~~	~~Full amount of the copayment~~
~~Speech therapy~~	~~$1 copayment~~	~~Full amount of the copayment~~
~~Chiropractic office visit~~	~~$2 copayment~~	~~Full amount of the copayment~~
~~Generic prescription drug or an atypical anti-psychotic drug if no generic equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medicare Part D drug coverage~~	~~$1 copayment~~	~~Full amount of the copayment~~
~~Preferred brand name drug for a recipient who does not have Medicare Part D drug coverage~~	~~$2 copayment~~	~~Full amount of the copayment~~
~~Nonpreferred brand name drug for a recipient who does not have Medicare~~	~~5% coinsurance, not to exceed $20 per nonpreferred~~	~~Full amount of the coinsurance, not to exceed $20 per nonpreferred brand name~~

~~Part D drug coverage~~	~~brand name drug prescription~~	~~drug prescription~~
~~Emergency room for a nonemergency visit~~	~~5% coinsurance, up to a maximum of $6~~	~~No deduction~~
~~DMEPOS~~	~~Three (3) percent coinsurance not to exceed $15 per item~~	~~The amount of the coinsurance or, if applicable, $15~~
~~Podiatry office visit~~	~~$2 copayment~~	~~Full amount of the copayment~~
~~Ophthalmological or optometric office visit (99000 series evaluation and management codes)~~	~~$2 copayment~~	~~Full amount of the copayment~~

~~(2) Physician services shall:~~

~~(a) Include care provided by a physician, a certified pediatric and family nurse practitioner, a nurse midwife, an advanced registered nurse practitioner, or a physician assistant; and~~

~~(b) Not include a visit to a federally-qualified health center, rural health clinic, or a primary care center.~~

~~(3) A recipient shall not be liable for more than:~~

(a) $225 per calendar year for prescription drug copayments or coinsurance; or

(b) $225 per calendar year for service copayments or coinsurance.

(4) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

(5) If a service or benefit is not listed in the global choices cost-sharing grid, the cost-sharing obligation shall be $0 for that service for an individual in the global choices benefit plan.

Section 5. Optimum Choices Copayments and Coinsurance. (1) Except for an individual excluded pursuant to Section 6(1) of this administrative regulation, a recipient of the optimum choices plan shall pay the copayment or coinsurance amount established in this table, with the corresponding provider reimbursement deductions.

Benefit	Copayment or Coinsurance Amount	Amount of Copayment or Coinsurance Deducted from Provider Reimbursement
Acute inpatient hospital admission	$10 copayment	Full amount of the copayment
Outpatient hospital or ambulatory surgical center visit	$3 copayment	Full amount of the copayment
Generic prescription drug or an atypical antipsychotic drug if no ge-	$1 copayment	Full amount of the copayment

~~neric equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medicare Part D drug coverage~~		
~~Preferred brand name drug for a recipient who does not have Medicare Part D drug coverage~~	~~$2 copayment~~	~~Full amount of the copayment~~
~~Nonpreferred brand name drug for a recipient who does not have Medicare Part D drug coverage~~	~~5% coinsurance, not to exceed $20 per nonpreferred brand name drug prescription~~	~~Full amount of the coinsurance, not to exceed $20 per nonpreferred brand name drug prescription~~
~~Emergency room for a nonemergency visit~~	~~5% coinsurance, up to a maximum of $6~~	~~No deduction~~
~~DMEPOS~~	~~3% coinsurance up to a maximum of $15 per item~~	~~The amount of the coinsurance or, if applicable, $15~~
~~Podiatry office visit~~	~~$2 copayment~~	~~Full amount of the copayment~~

~~(2) A recipient shall not be liable for more than:~~

~~(a) $225 per calendar year for prescription drug copayments or coinsurance; or~~

~~(b) $225 per calendar year for service copayments or coinsurance.~~

~~(3) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.~~

~~(4) If a service or benefit is not listed in the optimum choices cost-sharing grid, the cost-sharing obligation shall be $0 for that service or benefit for an individual in the optimum choices benefit plan.~~

~~Section 6.~~] Copayment[~~, Coinsurance and Premium~~] General Provisions and Exemptions[~~Exclusions~~]. (1)(a) No recipient shall be exempt from paying the eight (8) dollar copayment for a nonpreferred brand name drug prescription.

(b) Except for the mandatory copayment referenced in paragraph (a) of this subsection, the department shall impose no cost sharing for the following:

1.[~~(a)~~] A service furnished to an individual who has reached his or her 18th birthday, but has not turned nineteen (19), and who is required to be provided medical assistance under 42 U.S.C. 1396a(a)(10)(A)(i)(I), including services furnished to an individual with respect to whom aid or assistance is made available under Title IV, Part B (42 U.S.C. 620 to 629i) to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under Title IV, Part E (42 U.S.C. 670 to 679b), without regard to age;

2.[~~(b)~~] A preventive service [~~(for example, well baby and well child care and immunizations) provided to a child under eighteen (18) years of age regardless of family income~~];

3.[~~(c)~~] A service furnished to a pregnant woman;

4.[~~(d)~~] A service furnished to a terminally ill individual who is receiving hospice care as defined in 42 U.S.C. 1396d(o);

5.[~~(e)~~] A service furnished to an individual who is an inpatient in a hospital, nursing facility, intermediate care facility for individuals with an intellectual disability, or other medical institution, if the individual is required, as a condition of receiving services in the institution under Kentucky's Medicaid Program, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;

6.[~~(f)~~] An emergency service as defined by 42 C.F.R. 447.53;

7.[~~(g)~~] A family planning service or supply as described in 42 U.S.C. 1396d (a)(4)(C); or

8.[~~(h)~~] A service furnished to a woman who is receiving medical assistance via the application of 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa).

(2) The department has determined that any individual liable for a copayment[~~, coinsurance amount or premium~~] shall:

(a) Be able to pay a required copayment[~~, coinsurance amount or premium~~]; and

(b) Be responsible for a required copayment[~~, coinsurance or premium~~].

(3) A pharmacy provider or supplier, including a pharmaceutical manufacturer as defined in 42 U.S.C. 1396r-8(k)(5), or a representative, employee, independent contractor or agent of a pharmaceutical manufacturer, shall not make a copayment [~~or coinsurance amount~~] for a recipient.

(4) A parent or guardian shall be responsible for a copayment[~~, coinsurance amount or premium~~] imposed on a dependent child under the age of twenty-one (21).

(5) Provisions regarding a provider's ability to deny a service or benefit based on a recipient's failure to make a required copayment [~~or coinsurance payment~~] shall be as established in:

(a) KRS 205.6312(4); and

(b) 2012 Ky. Acts ch. 144, Part I.G.3.b.(14)[~~2006 Ky. Acts ch. 252 and in accordance with 42 U.S.C. 1396o-1~~].

(6) A provider:

(a) Shall collect from a recipient the copayment[~~, coinsurance amount, or premium~~] as imposed by the department for a recipient in accordance with this administrative regulation;

(b) Shall not waive a copayment[~~, coinsurance amount, or premium~~] obligation as imposed by the department for a recipient; and

(c) May collect a copayment[~~, coinsurance amount, or premium~~] at the time a benefit is provided or at a later date.

(7) Cumulative cost sharing for [~~premium payments and~~] copayments for a family with children who receive benefits under Title XXI, 42 U.S.C. 1397aa to 1397jj, shall be limited to five (5) percent of the annual family income.

(8) [~~A monthly premium for a family who receives benefits under 42 U.S.C. 1396r-6(b) shall not exceed three (3) percent of:~~

~~(a) The family's average gross monthly income; or~~

~~(b) The family's average gross monthly income minus the average monthly costs of child care necessary for the employment of the caretaker relative.~~

~~(9)~~] In accordance with 42 C.F.R. 447.82, the department shall not increase its reim-

bursement to a provider to offset an uncollected copayment[~~, coinsurance amount or premium~~] from a recipient.

[~~Section 7. Premiums for KCHIP - Separate Program Recipients.~~

~~(1) A family with children participating in the KCHIP-Separate Program shall pay a premium of twenty (20) dollars per family, per month.~~

~~(2)(a) The family of a new KCHIP-Separate Program eligible shall be required to pay a premium beginning with the first full month of benefits after the month of application.~~

~~(b) Benefits shall be effective with the date of application if the premium specified in paragraph (a) of this subsection has been paid.~~

~~(3) Retroactive eligibility as described in 907 KAR 20:010, Section 1(3), shall not apply to a recipient participating in the KCHIP-Separate Program.~~

~~(4)(a) If a family fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the first benefit month for which the premium has not been paid.~~

~~(b)1. A KCHIP-Separate Program recipient shall be eligible for reenrollment upon payment of the missed premium.~~

~~2. If twelve (12) months have elapsed since a missed premium, a KCHIP-Separate Program recipient shall not be required to pay the missed premium before reenrolling.~~

~~Section 8. Premiums for Transitional Medical Assistance Recipients. (1) A family receiving a second six (6) months of TMA, whose monthly countable earned income is greater than 100 percent of the federal poverty limit, shall pay a premium of thirty (30) dollars per family, per month.~~

~~(2) If a TMA family fails to make two (2) consecutive premium payments, benefits~~

~~shall be discontinued at the end of the benefit month for which the premium has not been paid unless the family has established to the satisfaction of the department that good cause existed for failure to pay the premium on a timely basis. Good cause shall exist under the following circumstances:~~

~~(a) An immediate family member living in the home was institutionalized or died during the payment month;~~

~~(b) The family was victim of a natural disaster including flood, storm, earthquake, or serious fire;~~

~~(c) The caretaker relative was out of town for the payment month; or~~

~~(d) The family moved and reported the move timely, but the move resulted in:~~

~~1. A delay in receiving the billing notice; or~~

~~2. Failure to receive the billing notice.~~]

Section 4.[~~9.~~] Premiums for Medicaid Works Individuals. (1)(a) A Medicaid works individual shall pay a monthly premium that is:

1. Based on income used to determine eligibility for the program; and

2. Established in subsection (2) of this section.

(b) The monthly premium shall be:

1. Thirty-five (35) dollars for an individual whose income is greater than 100% but no more than 150% of the FPL;

2. Forty-five (45) dollars for an individual whose income is greater than 150% but no more than 200% of the FPL; and

3. Fifty-five (55) dollars for an individual whose income is greater than 200% but no more than 250% of the FPL.

(2) An individual whose family income is equal to or below 100% of the FPL shall not be required to pay a monthly premium.

(3) A Medicaid works individual shall begin paying a premium with the first full month of benefits after the month of application.

(4) Benefits shall be effective with the date of application if the premium specified in subsection (1) of this section has been paid.

(5) Retroactive eligibility pursuant to 907 KAR 20:010, Section 1(3) shall not apply to a Medicaid works individual.

(6) If a recipient fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the first benefit month for which the premium has not been paid.

(7) A Medicaid works individual shall be eligible for reenrollment upon payment of the missed premium providing all other technical eligibility, income, and resource standards continue to be met.

(8) If twelve (12) months have elapsed since a missed premium, a Medicaid works individual shall not be required to pay the missed premium before reenrolling.

[~~Section 10. Notices and Collection of Premiums. (1) Premiums shall be collected in accordance with Sections 7, 8, and 9 of this administrative regulation.~~

~~(2) The department shall give advance written notice of the:~~

~~(a) Premium amount; and~~

~~(b) Date the premium is due.~~

~~(3) To continue to receive benefits, a family shall pay a premium:~~

~~(a) In full; and~~

~~(b) In advance.~~

~~(4) If a family pays the required premiums semiannually or quarterly in advance, they shall receive a ten (10) percent discount.~~]

Section 5.[~~11.~~] Provisions for Enrollees[~~Recipients in Medicaid-Managed Care~~]. [~~(1)~~] A managed care organization[~~entity~~]:

(1)[~~(a)~~] Shall not impose [~~on a recipient receiving services through a managed-care entity operating in accordance with 907 KAR 1:705~~] a copayment on an enrollee[~~, coinsurance or premium~~] that exceeds a copayment[~~, coinsurance or premium~~] established in this administrative regulation; and

(2)[~~(b)~~] May impose on an enrollee[~~upon a recipient referenced in paragraph (a) of this subsection~~]:

(a)[~~1.~~] A lower copayment[~~, coinsurance or premium~~] than established in this administrative regulation; or

(b)[~~2.~~] No copayment[~~, coinsurance or premium~~].

[~~(2) A six (6) month guarantee of eligibility as described in 907 KAR 1:705, Section 3(6)] shall not apply to a recipient required to pay a premium pursuant to Section 7 of this administrative regulation.~~]

Section 6.[~~12.~~] Freedom of Choice. (1) In accordance with 42 C.F.R. 431.51, a recipient who is not an enrollee may obtain services from any qualified provider who is willing to provide services to that particular recipient.

(2) A managed care organization may restrict an enrollee's choice of providers to the providers in the provider network of the managed care organization in which the enrollee is enrolled except as established in:

(a) 42 C.F.R. 438.52; or

(b) 42 C.F.R. 438.114(c).

Section 7.[~~13.~~] Notice of Discontinuance, Hearings, and Appeal Rights. [~~(1) The department shall give written notice of, and an opportunity to pay, past due premiums prior to discontinuance of benefits for nonpayment of a premium.~~

~~(2)(a) If a family's income has declined, the family shall submit documentation showing the decline in income.~~

~~(b) Following receipt of the documentation, the department shall determine if the family is required to pay the premiums established in Section 7, 8, or 9 of this administrative regulation using the new income level.~~

~~(c) If the family is required to pay the premium and the premium has not been paid, the benefits shall be discontinued in accordance with Section 7(4)(a), 8(2), or/9(6) of this administrative regulation.~~

~~(d) If the family is not required to pay the premium, benefits shall be continued under an appropriate eligibility category.~~

~~(3) The department shall provide the recipient with an opportunity for a hearing in accordance with 907 KAR 1:560 upon discontinuing benefits for nonpayment of premiums.~~

~~(4)~~] An appeal of a department decision regarding the Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

Section 8. Effective Date. The cost sharing provisions and requirements established in this administrative regulation shall be effective beginning January 1, 2014.

Section 9. Federal Approval and Federal Funding. The department's copayment provisions established in this administrative regulation shall be contingent upon:

(1) The receipt of federal financial participation; and

(2) Centers for Medicare and Medicaid Services' approval.(29 Ky.R. 1458; Am. 2201; 2478; eff. 4-11-2003; 30 Ky.R. 1117; 1533; eff. 2-16-04; 32 Ky.R. 417; 925; 1111; eff. 1-6-06; 33 Ky.R. 607; 1386; 1568; eff. 1-5-07; 34 Ky.R. 1840; 2117; eff. 4-4-08.)

907 KAR 1:604E

REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:604E
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the cost sharing requirements and provisions for the Kentucky Medicaid program.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the cost sharing requirements and provisions for the Kentucky Medicaid program.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the cost sharing requirements and provisions for the Kentucky Medicaid program.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing the cost sharing requirements and provisions for the Kentucky Medicaid program.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This amendment eliminates references to four (4) benefit plans to which Medicaid recipients previously have been assigned (comprehensive choices, family choices, global choices, and optimum choices) along with the corresponding cost sharing for each benefit plan; establishes uniform cost sharing for Medicaid recipients (except for those who are exempt from cost sharing or are enrolled with a managed care organization); eliminates premiums; eliminates references to coinsurance as only copayments, rather than coinsurance, are imposed going forward; establishes that the eight (8) dollar copayment for a nonpreferred brand name drug applies to all Medicaid recipients (no exemptions); establishes that the Department for Medicaid Services (DMS) will reduce the provider's reimbursement by the amount of the copayment for a physician's office visit, dental office visit, and non-emergent emergency room visit (as DMS does with all other copayments); and inserts a definition of preventive services. DMS is repealing a related administrative regulation which establishes the four (4) benefit plans as there was little difference among the plans and the plans created an administrative burden for DMS, providers, and managed care organizations. As a result of eliminating the four (4) benefit plans there will be uniform cost sharing obligations. Cost sharing changes vary based on an individual's benefit plan but include raising the outpatient hospital/ambulatory surgical center copay from $3 to

$4, raising the preferred brand name drug copay from $2 to $4, changing the non-preferred brand name drug copay from five (5) percent of the cost (not to exceed $20) to $8, raising the copay for non-emergent care in an emergency room from $6 to $8, lowering the durable medical equipment copay from no more than $15 to a fixed copay of $4, increasing the podiatry office visit copay from $2 to $3, increasing the dental office visit copay from $2 to $3, raising the ophthalmological and optometry office visit copays from $2 to $3, increasing the physical therapy office visit from $2 to $3, increasing the speech therapy office visit copay from $1 to $3, establishing an occupational therapy office visit copay of $3, increasing the physician's office visit copay from $2 to $3, and increasing the rural health clinic office visit, the federally-qualified health center office visit, and primary care center office visit copays from $2 to $3. DMS no longer imposes premiums for participation in the Kentucky Children's Health Insurance Program (KCHIP); thus, DMS is deleting the provisions regarding premiums.

(b) The necessity of the amendment to this administrative regulation: Eliminating the four (4) benefit plans (and establishing uniform cost sharing provisions) is necessary as the plans have minimal differences in cost sharing and created an administrative burden for the Department for Medicaid Services, providers, and managed care organizations. DMS is eliminating provisions regarding premiums because DMS no longer charges premiums for KCHIP participation as the biennium budget suspended such premiums. Inserting a definition of preventive services is necessary to clarify the services exempt from cost sharing as preventive services for all ages (as mandated by the Affordable Care Act and federal regulation) are exempt from cost sharing. DMS adopted the definition of preventive services that comports with the relevant federal law and regulation. DMS is increasing cost sharing amounts for services as permitted by federal requirements in order to discourage inappropriate utilization of Medicaid services. DMS is not exempting anyone from the eight (8) dollar nonpreferred brand name drug copayment because for such drugs there will always be a preferred brand name drug option and DMS wants to encourage use of preferred brand name drugs over nonpreferred brand name drugs. Reducing provider's reimbursement by the amount of the copayment for physician's office visits, dental office visits, and non-emergent emergency room visits is necessary to comply with federal regulation and directive from the Centers for Medicare and Medicaid Services (CMS). Establishing that DMS's cost sharing is contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer monies from being spent in the event that federal matching funds are not provided.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by eliminating an administratively burdensome (for DMS and providers) benefit plan structure; complying with federal requirements; complying with the biennium budget; protecting Kentucky taxpayer monies in the event that federal matching funds are not provided; and by discouraging inappropriate utilization of Medicaid services.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the authorizing statutes by eliminating an administratively burdensome (for DMS and providers) benefit

plan structure; complying with federal requirements; complying with the biennium budget; protecting Kentucky taxpayer monies in the event that federal matching funds are not provided; and by discouraging inappropriate utilization of Medicaid services.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: All Medicaid recipients who are not exempt from cost sharing will be affected by the amendment as well as Medicaid providers for whose services cost sharing is applied.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Providers of services for which cost sharing is imposed will be required to impose cost sharing when providing the given service and recipients are responsible for paying cost sharing.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Providers may experience administrative cost associated with updating the cost sharing amounts per service or costs resulting from a Medicaid recipient refusing to pay a copayment obligation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients who receive preventive services will benefit from the lack of cost sharing applied to the services. Providers will benefit from a uniform cost sharing structure rather than a structure comprised of four (4) benefit plans with varying cost sharing obligations.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services (DMS) anticipates no additional cost, other than programming changes to its Medicaid Management Information System (MMIS), as a result of the amendment to this administrative regulation.

(b) On a continuing basis: The response to question (a) also applies here.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds from general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding will be necessary to implement the amendment.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment to this administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is applied in that some Medicaid recipients are exempt (by federal regulation or law) from most cost sharing obligations.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:604E
Agency Contact Person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(14), 42 U.S.C. 1396o, 42 C.F.R. 447.50 through 447.60, 42 C.F.R. 447.82, and 42 C.F.R. 438.108

2. State compliance standards. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry.

   KRS 194A.050(1) authorizes the Cabinet for Health and Family Services secretary to "formulate, promote, establish, and execute policies, plans, and programs and shall adopt, administer, and enforce throughout the Commonwealth all applicable state laws and all administrative regulations necessary under applicable state laws to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the Commonwealth and necessary to operate the programs and fulfill the responsibilities vested in the cabinet. The secretary shall promulgate, administer, and enforce those administrative regulations necessary to implement programs mandated by federal law, or to qualify for the receipt of federal funds and necessary to cooperate with other state and federal agencies for the proper administration of the cabinet and its programs."

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(14) authorizes a state's Medicaid program to impose cost sharing only as allowed by 42 U.S.C. 1396o. 42 U.S.C. 1396o establishes categories of individuals for whom a state's Medicaid program may not impose cost sharing as well as cost sharing and premium limits.

   42 C.F.R. 447.50 through 447.60 also establishes limits on cost sharing (based on income of the given Medicaid eligibility group); Medicaid populations exempt from cost sharing (children, pregnant women, institutionalized individuals for example); services exempt from cost sharing (emergency services, family planning services to child-bearing age individuals); prohibition against multiple cost sharing for one (1) service; a requirement that state Medicaid programs do not increase a provider's reimbursement by the amount of cost sharing; and a requirement that managed care organizations' cost sharing must comply with the aforementioned federal regulations.

   42 C.F.R. 447.82 requires a state's Medicaid program to reduce its reimbursement to a provider by the amount of any cost sharing imposed on a recipient for a given service.

   42 C.F.R. 438.108 establishes that a managed care organization's cost sharing must

comply with the federal cost sharing requirements for Medicaid established in 42 C.F.R. 447.50 through 42 C.F.R. 447.60.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 1:604E
Agency Contact Person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services (DMS) will be affected by the amendment to this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. Federal regulations 42 C.F.R. 447.50 through 42 C.F.R. 447.60, 42 C.F.R. 447.82, and this administrative regulation authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.
   (c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) anticipates no additional cost, other than programming changes to its Medicaid Management Information System (MMIS), as a result of the amendment to this administrative regulation.
   (d) How much will it cost to administer this program for subsequent years? The response to question (c) also applies here.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): ____
Expenditures (+/-): ____
Other Explanation: